

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maurice T. Adams				2a. DATE OF DEATH MONTH DAY YEAR December 8, 1983		2b. HOUR A 2:09 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 27 1908		6. AGE [IN YEARS (LAST BIRTHDAY)] 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Trappe		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19 W. Maple Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Custom label	
13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Trappe	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony B. Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jane Carroll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No				16b. SOCIAL SECURITY NO. 220-01-0255		17. INFORMANT ADDRESS Erva H. Adams, (see item 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 m & 1/2 hr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>23 Nov</u> , 19 <u>83</u> , to <u>8 Dec</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>6 Oct</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D. Easton, Maryland 21601				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-10-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home, Easton, Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>	

20% COTTON FIBRE

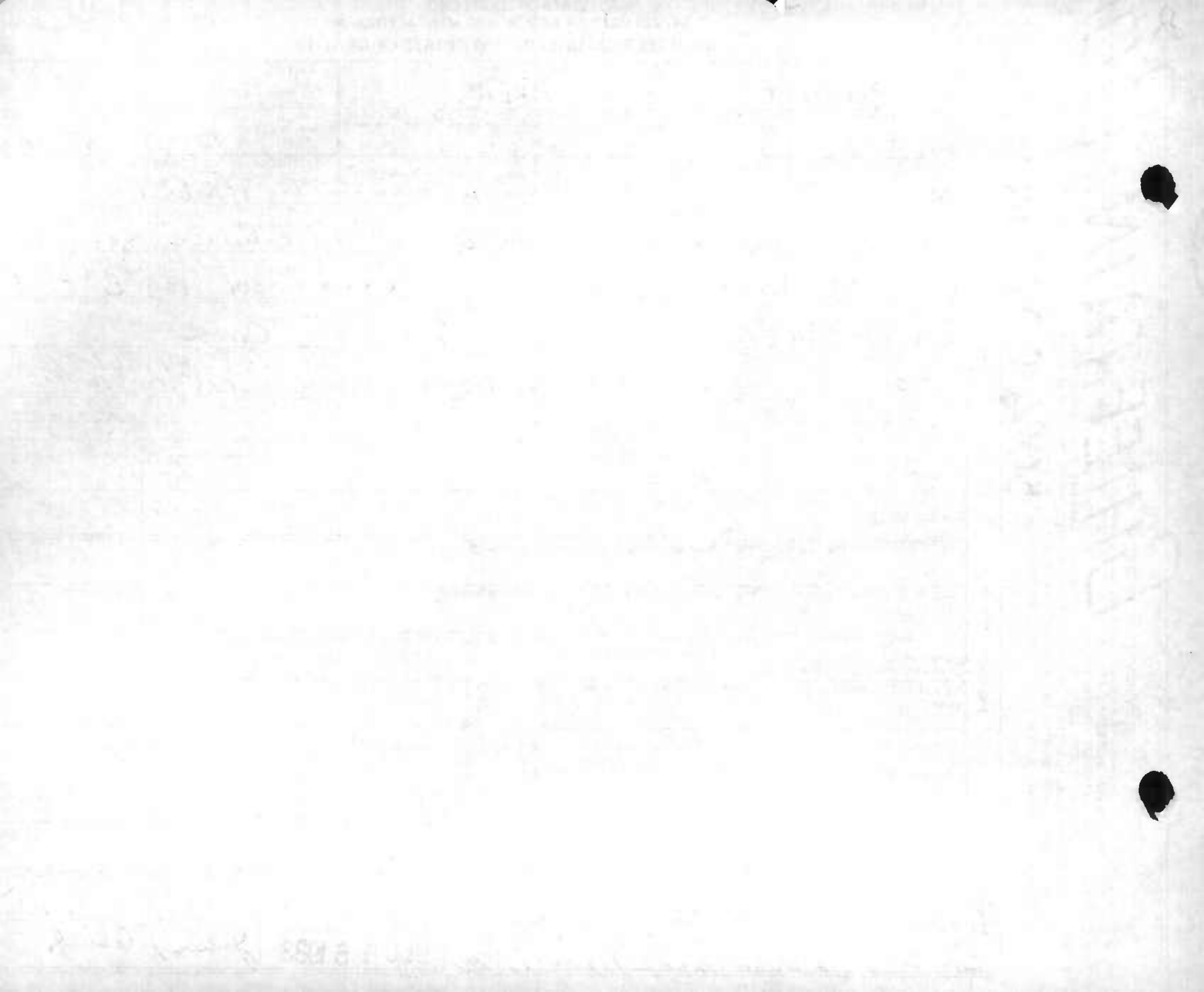
CHIEFTAIN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CLARENCE AKERS										2b. DATE KNOWN OF DEATH MATED 12-7-83	
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 12-7-83		2d. HOUR 8:40 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		MD.		
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL @ EASTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE MD			13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Ret #3, Box 139 B		
14. FATHER'S NAME FIRST Robert MIDDLE AKERS LAST 					15. MOTHER'S MAIDEN NAME FIRST Lillie MIDDLE Gross LAST 			16. SOCIAL SECURITY NO. Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					17. INFORMANT ADDRESS Dorothy Murray Red #1, Box 99 Ridgely, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Just			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Louis S. Nelly		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED 11-7-83					
EXAMINER'S NAME (TYPE OR PRINT) Louis S. Nelly		ADDRESS Easton Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION CITY OR TOWN Denton COUNTY Caroline STATE MD					
24. FUNERAL DIRECTOR NAME ERIC		ADDRESS L. Dashiell		P.O. Box 606 EASTON, MD		25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical investigator must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03 34241

FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) James Emory Barnes		2a. DATE OF DEATH MONTH DAY YEAR December 27, 1983	
3. SEX Male		3b. HOUR 3:45 A.M.	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 27 1908	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Industrial	
13a. STATE Maryland		13b. CITY OR TOWN Catonsville	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 20 Del Roy Av. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Emory Guy Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gordie Huenes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-0700	
17. INFORMANT ADDRESS Ms. Connie Bridner P.O. Box 162 Academy St Easton, Md Hurlock Md		APPROXIMATE BETWEEN CAUSE 31A-43	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure 5849 DUE TO, OR AS A CONSEQUENCE OF: (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): 1. Atherosclerotic Heart Disease 2. Pulmonary Emboli			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED (BY FIRE <input type="checkbox"/> HOT WIRE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23b. DATE SIGNED		23c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
24. SIGNATURE W. H. Manigold		25. DEGREE MD	
26. PHYSICIAN'S NAME (TYPE OR PRINT) MANIGOLD		27. ADDRESS Easton Memorial Hospital	
28a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		28b. DATE 12-30-83	
29a. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		29b. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Howard MD	
30. FUNERAL DIRECTOR NAME SLACK Funeral Home		31. DATE REC'D. BY REGISTRAR JAN 3 1984	
ADDRESS P.O. Box 263 Ellicott City MD		32. REGISTRAR'S SIGNATURE John J. Smith	

James E. Jones
December 27, 1933

Talbot County

Memorial Hospital

Enclosed for the Memorial Hospital is a check for \$100.00, which is the amount of the subscription to the hospital fund. The subscription was made by the members of the church, and the amount is being paid to the hospital for the use of the fund.

The subscription was made by the members of the church, and the amount is being paid to the hospital for the use of the fund. The subscription was made by the members of the church, and the amount is being paid to the hospital for the use of the fund.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William BAYNARD</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 27 1983</i>		2b. HOUR MIN. <i>11 50 P.M.</i>
1. SEX <i>Male</i>	4. RACE <i>B</i>	3. AGE OF BIRTH MONTH DAY YEAR <i>8 - 2 - 27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Caroline</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>TA/lot</i> MD.	
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MD.</i>		13b. CITY OR TOWN <i>Caroline Denton</i>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <i>P.O. Box 533 21629</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Baynard</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Allen Baynard</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>unk.</i>		17. INFORMANT ADDRESS <i>Bruce Lee Baynard, P.O. Box 533, Dent</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Respiratory Arrest*

2910

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) *Anoxic encephalopathy & coma*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Aspiration pneumonia; previous resp arrest*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutes

10 days

10 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Right lower lobe pneumonia; Delirium tremens; Alcoholism

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>12/22</i> , 19 <i>82</i> , to <i>12/17</i> , 19 <i>82</i> , that (we) last saw the deceased alive on <i>12/22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Shaffer</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/29</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph M. Shaffer</i>				22e. ADDRESS <i>Kerr Avenue, Denton MD.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/31/83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chapel Cent. Dent.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Denton, Caroline, MD.</i>	
24. FUNERAL DIRECTOR NAME <i>Russell F. Davis</i>		ADDRESS <i>514 Kenton Way St.</i>		25a. DATE REC'D. BY REGISTRAR <i>Jan 6 1984</i>	
25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>					

[Faint, illegible handwritten notes and markings are visible across the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ANITA SPENCER BLANKS					2a. DATE OF DEATH MONTH DAY YEAR 12/21/83			2b. HOUR MIN. 600 P.M.	
3. SEX FEMALE		4. RACE NEGROE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 8, 1888		6. AGE (IN YEARS LAST BIRTHDAY) YEARS 95		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE RAILROAD AVE. 21663	
14. FATHER'S NAME FIRST MIDDLE LAST ISACCA SPENCER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE CHANEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 218-05-7997		17. INFORMANT ADDRESS 202 LOCUST ST. ST. MICHAELS, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 21663 4292 DUE TO, OR AS A CONSEQUENCE OF: (b) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. DIABETES CHRONIC LYMPHOCYTIC LEUKEMIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from 11/17 , 19 83 , to 12/21 , 19 83 , that (ii) (we) lost saw the deceased alive on 12/20 , 19 83 , and that in (iii) (our) opinion death occurred on the date and hour and from the causes stated above (ii) (we) did (did not) view the body after death.									
22b. SIGNATURE W.B. Bremer			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM BREMER M.D.					22e. ADDRESS E. CHESTNUT SST. ST. MICHAELS, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY THOMAS MEMORIAL ST. MICHAELS TALBOT Md.		23d. LOCATION CITY OR TOWN COUNTY STATE 21663		
24. FUNERAL DIRECTOR NAME Shirley E. Ronald St. Michaels Md.					25. DATE REC'D. BY REGISTRAR (R25b. REGISTRAR'S SIGNATURE) DEC 30 1983				

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[illegible]

ST-003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked in item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHRISTOPHER PAUL BYINGTON			2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 83			2b. HOUR 12:15 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 12 DAY 25 YEAR 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 8	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Royal Oak		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Curtis MIDDLE Paul LAST Byington		15. MOTHER'S MAIDEN NAME FIRST Lisa MIDDLE Lee LAST Patchett		17. ADDRESS G. Wayne Patchett Easton, Md. 21601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Intracranial Hemorrhage resulting from severe prematurity 7650 DUE TO, OR AS A CONSEQUENCE OF (b) Severe Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Severe Prematurity; Possible Injury (8 hrs.)	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). NA	
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19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET NA CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-28 19 83 , to 12-28 19 83 , that (I) (we) last saw the deceased alive on 12:15 PM 12-28-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sylvia A. Gonzalez-Diaz DEGREE Doctor of Medicine				22c. DATE SIGNED 1-2-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SILVIA A. GONZALEZ-DIAZ				22e. ADDRESS DUTCHMAN'S LAKE, EASTON, M.D.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-83		23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		23d. LOCATION CITY OR TOWN Sherwood COUNTY Talbot STATE Maryland	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home ADDRESS Easton, Md. 21601				25a. DATE RECEIVED BY REGISTRAR JAN 5 1984 25b. REGISTRAR'S SIGNATURE John J. Smith			

JAN 5 1954

1-2-54

1-2-54

(P.L.)

British Museum

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy		FIRST L.		MIDDLE Campbell		LAST		2a. DATE OF DEATH MONTH 12 DAY 27 YEAR 83				2b. HOUR 1²⁵ P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH June DAY 19 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.				# UNDER 1 YEAR MONTHS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.							
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher				12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 504 S. Aurora St. 21601					
14. FATHER'S NAME FIRST Spencer MIDDLE LAST Vanasadalan				15. MOTHER'S MAIDEN NAME FIRST Wilhemina MIDDLE LAST Walzer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-36-7313		17. INFORMANT Walter H. Campbell (see item 13e)				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3352 Amyotrophic Lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (b) 3352 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 82 to 12/27 19 83 , that (I) (we) lost saw the deceased alive on 12/27 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (they) did not view the body after death.													
22b. SIGNATURE Gregg Rhodes		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/20/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregg Rhodes, M.D.		22e. ADDRESS 400 Dutchman's Lane Easton, MD 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-83		23c. NAME OF CEMETERY OR CREMATORY Zion Luth. Church Cemetery		23d. LOCATION CITY OR TOWN Enola COUNTY Cumberland STATE Pa.							
24. FUNERAL DIRECTOR NAME Newnam Funeral Home, Easton, Md. 21601		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 30 1983		25b. REGISTRAR'S SIGNATURE Samuel...							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(REMARKS: If item 21 is marked as (a) above, any injury, or other traumatic event, the medical examiner must be notified at once.)

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner's Report

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 3 4 2 4 6							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
3. SEX				4. RACE				5. DATE OF BIRTH MONTH DAY YEAR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE				13b. CITY OR TOWN				13c. STREET ADDRESS / ZIP CODE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				22a. I certify that (I) (the hospital) attended the deceased from 11-22-83, to 12-21-83, that (I) (we) lost saw the deceased alive on 12-20-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				22b. SIGNATURE DEGREE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION CITY OR TOWN COUNTY STATE				23e. DATE RECEIVED BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			

RECEIVED
APR 11 1904

100 W. Chestnut St.
Philadelphia, Pa.
April 11, 1904
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the
above-captioned case. The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. Edgar Hoover

Enclosed for you are two copies of the report of the
Commissioner of the Bureau of Investigation, dated April 10, 1904, in relation to the above-captioned case.
Very respectfully,
J. Edgar Hoover

Very respectfully,
J. Edgar Hoover
Special Agent in Charge
Bureau of Investigation
U. S. Department of Justice
Washington, D. C.

Original
J. Edgar Hoover
Bureau of Investigation
U. S. Department of Justice
Washington, D. C.

1 - FOR
STATE
REGISTRAR

Item #5 Film #G588
2/6/84 jp

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST Ollie		MIDDLE Copper		LAST Copper		2a. DATE OF DEATH		MONTH Dec	DAY 19	YEAR 83	2b. HOUR 35 3 AM	
3. SEX male		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR 9 4 04			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD							
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farmer				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE Md		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 6 Box 476						
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Copper						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tilghman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT Joyce		ADDRESS Copper				

18. CAUSE OF DEATH (Enter one or more cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Brain Syndrome, Seizure's, Left Lower Lobe Pneumonia</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> , to <u>Dec 16</u> , 19 <u>83</u> , that (I) (we) lost <small>view the deceased alive on</small> <u>Dec 16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.			
22a. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED <u>12-19-83</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS	
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/22/83	23c. NAME OF CEMETERY OR CREMATORY Richardson	23d. LOCATION CITY OR TOWN Easton	COUNTY TA	STATE MD
24. FUNERAL DIRECTOR NAME George H. W. ...			25a. DATE REC'D. BY REGISTRAR JAN 5 1984		
ADDRESS ...			25b. REGISTRAR'S SIGNATURE John E. ...		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 34248	
1. DECEASED NAME (TYPE OR PRINT) Kenneth M Covey						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12 5 1983		2b. HOUR 2:15 PM		2c. DATE PRONOUNCED DEAD 12 5 1983	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 - 3-1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 5 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSP, EASTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accts. Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD5, Box 427 21601	
14. FATHER'S NAME FIRST MIDDLE LAST James C. Covey, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marvel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 215-14-3239		17. INFORMANT ADDRESS Nancy S. Covey (see item 13e)			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Hardness Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Primary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. Lane Wroth				M.D. R. Lane Wroth				TITLE (SPECIFY) Medical Examiner		DATE SIGNED 12-6-83	
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12-6-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Md. 21601						25a. DATE REC'D. BY REGISTRAR DEC 7 - 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

BP_____

DHMH - 16 50M -
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
3. SEX				4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
William Lytle Crozier				White		July 7 1916		67 YRS.		8 PM	
Male											
Pennsylvania				U.S.A.				Talbot			
Easton				Memorial				Superintendent		Metal screw mach	
Maryland				Talbot		Easton		318 S. Aurora St. 21601			
Alfred W. Crozier				Elizabeth Lytle							
No				159-14-2205		Henriette A. Crozier (see item 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1629</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Spring</u> 19 <u>83</u> , to <u>Dec</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Dec 7</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>P. Gregg Rhodes M.D.</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>12/8/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. GREGG RHODES, M.D.</u>						22e. ADDRESS <u>400 Ditchman Lane, Easton, Md 21601</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. STATE			
Burial		12-11-83		Jefferson Mem Park		Pleas. Hills		Allegheny Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home Easton, Md. 21601						DEC 12 1983		<u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 together filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 - 34250

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Miriam S. Dennis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-30-83</i>			2b. HOUR MIN. <i>5:40</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 16, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>77</i>		7. IF UNDER 1 YEAR IF UNDER 2 YEARS HOURS MIN. <i>5:40</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD				
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. STATE <i>MD</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>William Hill Manor, 21601</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles H. Schnefe, Jr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertie Auld</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>215 48 3591</i>			17. INFORMANT ADDRESS <i>John M. Dennis, Jr. Same</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute respiratory failure</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ISCVD & coronary artery disease</i> 6 hours. 10 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>middle cerebral artery thrombosis, COPD</i>										
19a. DATE OF OPERATION <i>-</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>-</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>- - - - -</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1969</i> , 19 <i>83</i> , to <i>12/30</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12/30</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Albert T. Dawkins</i> MD						DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/31/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT T. DAWKINS JR. M.D.</i>						22e. ADDRESS <i>Route 3 Box 127 EASTON MARYLAND 21601</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/4/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick, MD</i>			
24. FUNERAL DIRECTOR NAME <i>Henry W. Jenkins & Sons Co.</i> 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR <i>JAN 3 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conick</i>		

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George W. Jones & Sons Co.
New York City, N.Y. 10012

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) VIRGINIA C. ELRICK			2a. DATE OF DEATH MONTH DAY YEAR 12-17-83		2b. HOUR 10:50 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 23, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.		
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tavern Owner	12b. KIND OF BUSINESS OR INDUSTRY Bartender	
13a. STATE Maryland		13b. COUNTY Caroline	13c. CITY OR TOWN Federalburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Liberty Rd., Fed., Md. 21632	
14. FATHER'S NAME FIRST MIDDLE LAST Luther H. Covey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy M. Nichols			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-16-3494		17. INFORMANT ADDRESS Dale Elrick P.O. Box 43 Seaford, Del		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2788 IMMEDIATE CAUSE (a) Chronic respiratory failure 4 months DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Obesity (Pickwick Syndrome) 4 years DUE TO, OR AS A CONSEQUENCE OF and Chronic Obstructive Lung Dis 4 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 83 , to Dec , 19 83 that (I) (we) saw the deceased alive on Dec 17 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE Phyllis Rhodes		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. G. RHOADS		22e. ADDRESS MD 400 Ditchmans Lane, Easton, Md 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fed. Caroline Md.
24. FUNERAL DIRECTOR NAME Harvey A. Williams		ADDRESS Federalburg, Md		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN A. ENGLE			2a. DATE OF DEATH MONTH DAY YEAR 12-26-83		2b. HOUR 8:55 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Preston, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria		12b. KIND OF BUSINESS OR INDUSTRY Preston Pub. S.
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 62		13f. ZIP CODE 21655		14. FATHER'S NAME FIRST MIDDLE LAST August Quidas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Joseph Walsh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-03-0439		17. INFORMANT ADDRESS 21655 Melvin R. Engle, Rt. 1, Box 62, Preston, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 12-25 19 83 , to 12-26 19 83 , that (I) (we) last saw the deceased alive on 12-25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b. SIGNATURE Stephen P. Carney				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				2e. ADDRESS Easton, Md. 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland
24. FUNERAL DIRECTOR NAME Tranpton-Hawkins Federalburg, Md.				25. DATE FILED BY REGISTRAR JAN 1 1984		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Catherine FINN			2a. DATE OF DEATH MONTH DAY YEAR 12 8 83		2b. HOUR 8^P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Dept.		12b. KIND OF BUSINESS OR INDUSTRY Supermarket	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Lister		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Greenlee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 218207456A		17. INFORMANT ADDRESS Mrs. Elizabeth Maynard, Maryland Wye Mills					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2389 IMMEDIATE CAUSE (a) Metastatic Carcinoid DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 1/2 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 15 Sep 1983 to 8 Dec 1983 , that (I) (we) lost saw the deceased alive on 8 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Carney M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/83		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md.	
24. FUNERAL DIRECTOR NAME More Funerals Inc Denton				25. DATE REC'D BY REGISTRAR DEC 16 1983			
25. REGISTRAR'S SIGNATURE John J. Carney							

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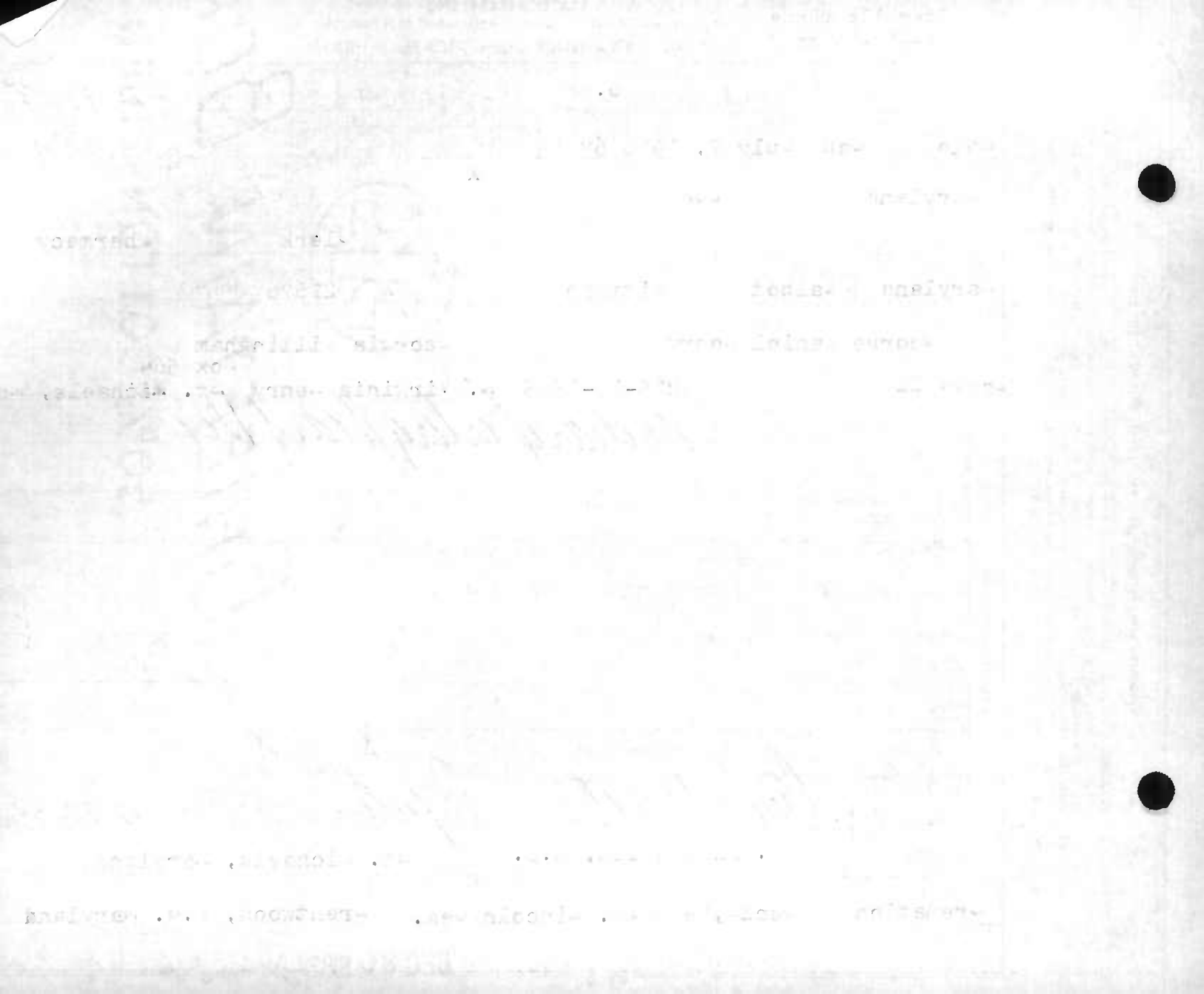
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PK-3. RETAIN PAGE 5. FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Item 13e phone 1- STATE 1--12-84 cn REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edward G. Henry										2a. DATE KNOWN OF DEATH ESTI- MATED Dec 21 1983										2b. HOUR 5:00 PM	
1. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Dec 21 1983		2d. HOUR 6:00 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot				MD.					
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY Pharmacy									
13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Wittman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21676 Rural											
14. FATHER'S NAME FIRST MIDDLE LAST George Daniel Henry						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Gillingham															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No SW II				16b. SOCIAL SECURITY NO. 215-10-1585		17. INFORMANT M. Virginia Henry, St. Michaels, Md.				Address Box 564											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Pulmonary Heart Dis DUE TO, OR AS A CONSEQUENCE OF (c) Box 564 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE R. Lane Wroth				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER R. LANE WROTH, M.D.				DATE SIGNED 12-22-83									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS St. Michaels, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Dec 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Maryland											
24. FUNERAL DIRECTOR NAME Hammon E. Leonard				ADDRESS St. Michaels, Md.				25a. DATE REC'D. BY REGISTRAR DEC 30 1983				25b. REGISTRAR'S SIGNATURE John J. Grier									

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

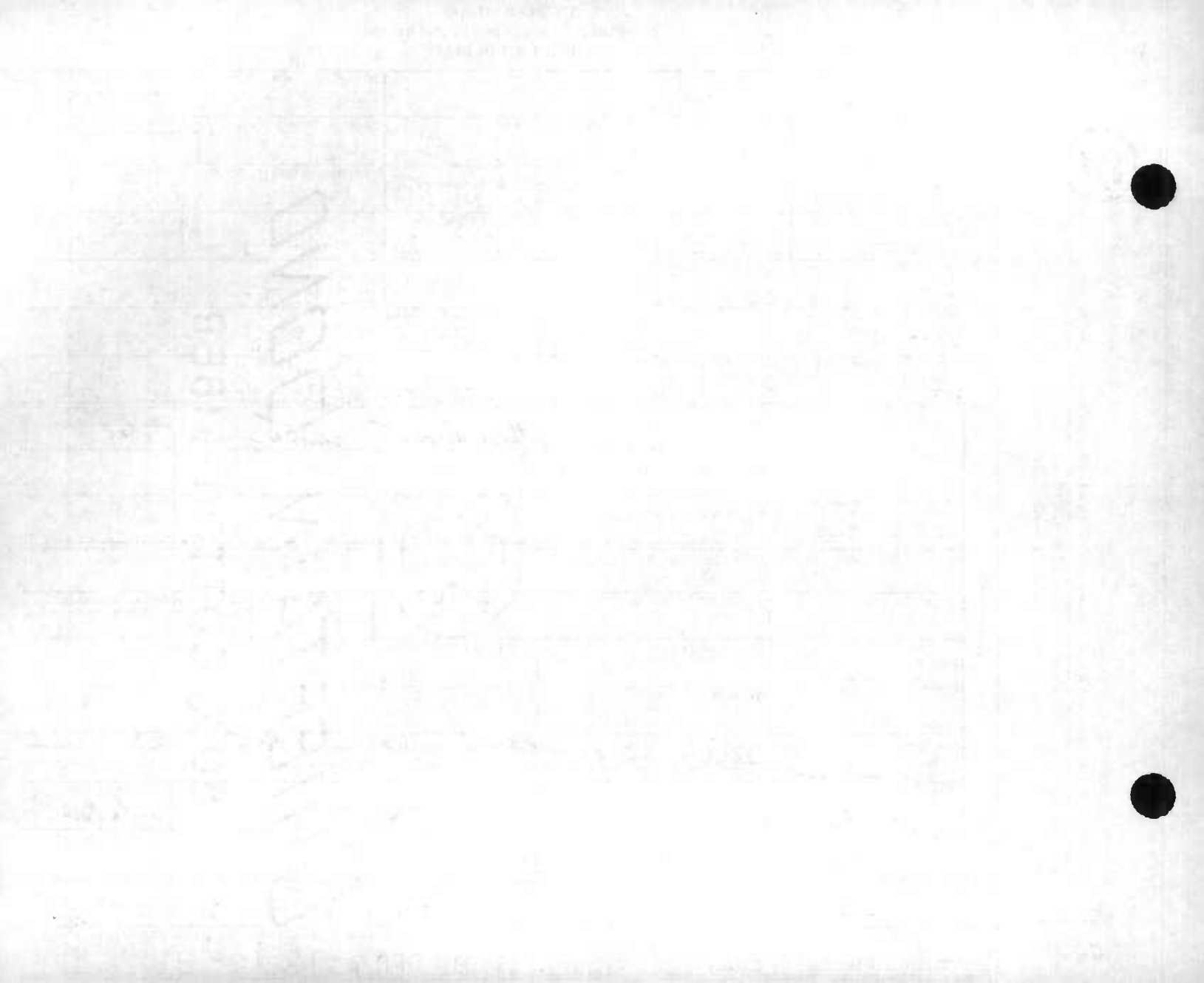
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	MIN.
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		December 1, 1983		10:05 ^P
Emma Belle Hopkins								
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
Female	White	June 5, 1894		89 YRS		MONTHS		DAYS
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
Maryland		USA		Talbot		MONTHS		DAYS
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Meridan Nursing Cen.-ThePines		secretary				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland		Talbot	Easton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	202 E. Dover St. 21601			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST		FIRST MIDDLE LAST						
William James Hopkins Jr.		Sallie Wright Stafford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no		213-01-8156		Philip Hopkins, 108 Earle Av., Easton 21601				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I: DEATH WAS CAUSED BY:		(3)						
IMMEDIATE CAUSE (a) 4370		Cerebral aneurysm & seizure						
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)						
DUE TO, OR AS A CONSEQUENCE OF		(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 28 Nov 83, 19 83, to 1 Dec 83, 19 83, that (I) (we) last saw the deceased alive on 28 Nov 83, and that in (my) (our) opinion death occurred on the date and hour and on the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Thurston Harrison						12/5/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
THURSTON HARRISON								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12-5-83	Spring Hill Cem.		CITY OR TOWN COUNTY STATE			
					Easton Talbot Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS		DEC 7 - 1983		John J. Carver				
Newnam Funeral Home, Easton, Md. 21601								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
marion J.		Hutson						12 27 83		2 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Male		White		3 15 1908		75 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Easton Memorial Hosp						Farmer		Farm	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a. STREET ADDRESS / ZIP CODE			
MD		CA		Denton				Rt. 3 Box 84		21629	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Hutson				Lula Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		218-34-9381		Cornelia Hutson		Denton, MD 21629					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
5609 IMMEDIATE CAUSE (a) <i>Cardiac artery thrombosis, refractory to treatment</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>kidney failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>intestinal obstruction</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
MD Crowley		Easton, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-31-83		Ridgely Cemetery		Ridgely CA Carroll MD					
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE							
John E. Bowles		JAN 4 1984									

BP

NOTES

Section 7

THURSDAY

EASTON HIGH SCHOOL

NOTES

Handwritten notes in cursive script, mostly illegible due to fading.

Handwritten notes at the bottom of the page, including the word "Account" and other illegible cursive text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will file this information.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Eileen Hope KEATING			2a. DATE OF DEATH MONTH DAY YEAR 12/3/83		2b. HOUR 5:33 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 16, 1910	6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? Great Britain	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.		
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife	12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Queen Anne's 13c. CITY OR TOWN Centreville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Greenlots Farm, R.D. #1, Box 221, 21617		
14. FATHER'S NAME FIRST MIDDLE LAST David Harry Prosser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie ----- Kelly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-58-0099	17. INFORMANT Husband ADDRESS R.D. #1, Box 221 Thomas J. Keating, Jr., Centreville, Md. 21617		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3352 Respiratory Arrest IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) Ankyrotrophic Lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-2-83 to 12-3-83 , that (I/we) last saw the deceased alive on 12-3-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas W. Fauntleroy, Jr., M.D.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 7, 1983	23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville Q.A.Co. Md.	
24. FUNERAL DIRECTOR NAME Barton Funeral Home ADDRESS James H. Barton, Jr., Centreville, Md. 21617		25a. RECEIVED BY HEALTH DEPT. 25b. REGISTRAR'S SIGNATURE DEC 9 1983			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		12 18 83	
FIRST John MIDDLE E LAST Lane		12 18 83		7 PM	
1. SEX		4. RACE		5. DATE OF BIRTH	
male		white		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Md.		U.S.A.		85 YRS.	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Easton		Memorial Hospital		Talbot MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE	
carpenter				Main St. (box #5) 21617	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST Louis MIDDLE Lane LAST Lane		FIRST Nellie MIDDLE Dadds LAST Dadds		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
217-52-0220		Louis Lane		Box #13, Church Hill Md. 21617	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cerebrovascular accident					
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Acute renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Lawrence D. Bohan				12-19-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Lawrence D. Bohan				Dutchman's Lane, Easton, Md 21644	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-21-83		Woodlawn Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
NAME		CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE	
Helfenbein Funeral Home		Easton Talbot Co. Md.		DEC 30 1983 John J. Coniff	
ADDRESS					
Chester, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at _____.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST LOVE			2a. DATE OF DEATH MONTH DAY YEAR 12/21/83			2b. HOUR 945P M				
3. SEX Female		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR 4 12 30		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 205 South St.	
14. FATHER'S NAME FIRST Roy MIDDLE Bailey LAST			15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Emory LAST			ADDRESS Helen Warner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -			16b. SOCIAL SECURITY NO. -		17. INFORMANT Helen Warner					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): End Stage Renal Failure treated by dialysis; Alcoholism								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours TRS		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 12/21/83 to 12/21/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)										
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12/22/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12/26/83		23c. NAME OF CEMETERY OR CREMATORY Deshields		23d. LOCATION CITY OR TOWN COUNTY STATE EASTON TN MD			
24. FUNERAL DIRECTOR NAME George Daskiel ADDRESS Easton Md					25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RENNARD DARRYL Magee			2a. DATE OF DEATH MONTH 12 DAY 29 YEAR 83			2b. HOUR 0035 M					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH Sept. DAY 26 YEAR 1961		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Easton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Trash Collector			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Caroline		13c. CITY OR TOWN Federalburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 111 Gerardi Blvd. 21632	
14. FATHER'S NAME FIRST James A. MIDDLE Raikes LAST 				15. MOTHER'S MAIDEN NAME FIRST Reba MIDDLE Stanley LAST 				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 217-82-0937				17. INFORMANT 111 Gerardi Blvd. burg, Md. 21632				17. INFORMANT Reba Magee, 111 Federal Gardens, Federalburg			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Acute Pancreatitis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Probable Alcohol Abuse**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 83 , to 12/29 , 19 83 , that (I) (we) last saw the deceased alive on 12/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley Bysshe Jr		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley Bysshe, M.D.				22e. ADDRESS Easton, Md. 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1984		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION CITY OR TOWN Federalburg COUNTY Caroline STATE Md.	
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24. FUNERAL DIRECTOR NAME Thompson-Hawkins ADDRESS Box 43 Federalburg		25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, item 18 should be examined and kept certified as such.



Male

Neuro

Sept. 26, 1951

SS

X

U.S.A.

Easton, Md.

Driver

Trash Collector
111 Gerard Blvd

111 Federal Gardens

X

Federalburg

Caroline

Maryland

James A. Raikes

Reba Stanley

111 Gerard Blvd. Bldg. Md. 21632

Reba Raikes, 111 Federal Gardens, Federalburg-

217-82-0937

No

Faint handwritten notes in the center of the page.

Easton, Md. 21601

Stanley Raikes, N.D.

Burial

Jan. 2, 1984 Federal Hill Cemetery Federalburg, Caroline, Md.

MEDICAL CERTIFICATION

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3. 4. 2. 6. 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George W. Murphy			2a. DATE OF DEATH MONTH 12 DAY 6 YEAR 83			2b. HOUR 1:57 P. M.	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH JUNE DAY 11 , YEAR 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital Easton md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	
12b. KIND OF BUSINESS OR INDUSTRY MARINE HDW.							
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN WILMANTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS - ZIP CODE SEWELL PT. RD. 21676							
14. FATHER'S NAME FIRST WILLIAM MIDDLE MURPHY LAST				15. MOTHER'S MAIDEN NAME FIRST MAGGIE MIDDLE SCHMIDT LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ---		16b. SOCIAL SECURITY NO. 213-05-4213		17. INFORMANT THOMAS E. MADDEN ADDRESS 111 CARVEL BEACH RD. BALTIMORE, Md. 21226			
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cerebral Cortex, Heart, Lungs DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Oct 19 83 to 6 Dec 19 83 , that (I) (we) last saw the deceased alive on 4 Dec 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)							
22b. SIGNATURE R. Lane Wroth, M.D.				DEGREE MD		22c. DATE SIGNED 12-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS St. Michaels, Md. 21663			
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL		23b. DATE DEC. 8, 1983		23c. NAME OF CEMETERY OR CREMATORY TILGHMAN CEMETERY		23d. LOCATION CITY OR TOWN TALBOT COUNTY MD. STATE	
24. FUNERAL DIRECTOR NAME James E. Zernard ADDRESS St. Michaels, Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1983 REGISTRAR'S SIGNATURE John J. Connel			

BP

12 12 1952

George W. Murphy



1952 12 12 1952

Todist

Memorial Hospital Eastern

1952 12 12 1952

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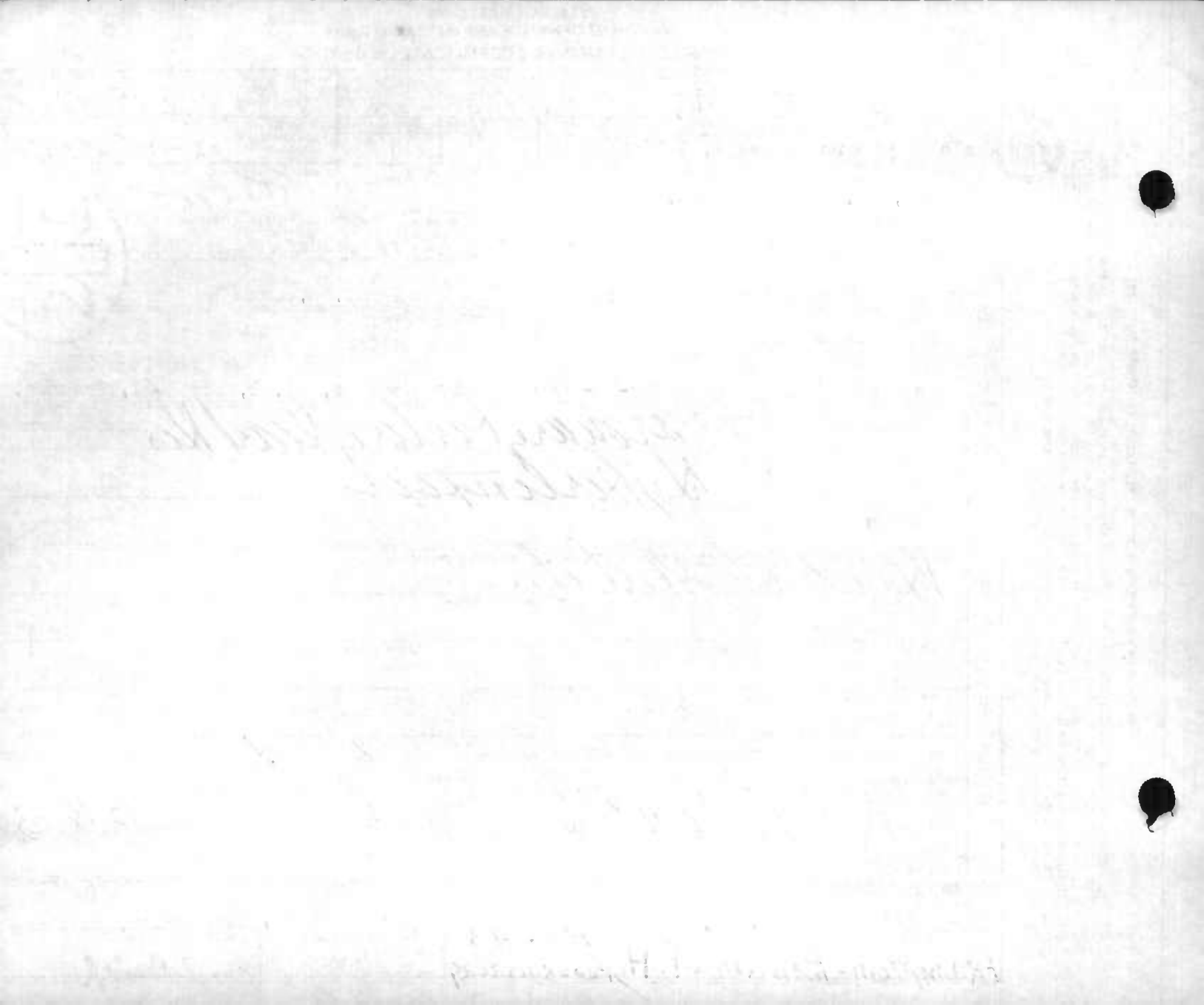
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Gilbert W.		MIDDLE M.		LAST Murray		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 12		DAY 15		YEAR 1983		2b. HOUR 11 AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH June 7, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12-15-1983		2d. HOUR 12 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Preston, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Tallbot											
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Welding Co.											
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 86									
14. FATHER'S NAME FIRST John Wesley		MIDDLE Murray		LAST		15. MOTHER'S MAIDEN NAME FIRST Velma		MIDDLE Hubbard		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 216-14-9040A		17. INFORMANT Denise Fowlkes, Rt. 1, Box 146A, Preston,		ADDRESS Maryland 21655									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)		DUE TO, OR AS A CONSEQUENCE OF Superficial lacerations															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Diabetic Mellitus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above; held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE R. Paul Croth		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 12-16-83											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 19, 1983		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester, Maryland											
24. FUNERAL DIRECTOR NAME FRAMPTON-HAWKINS		ADDRESS Box 43 FEDERSBURG		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John S. Givens											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

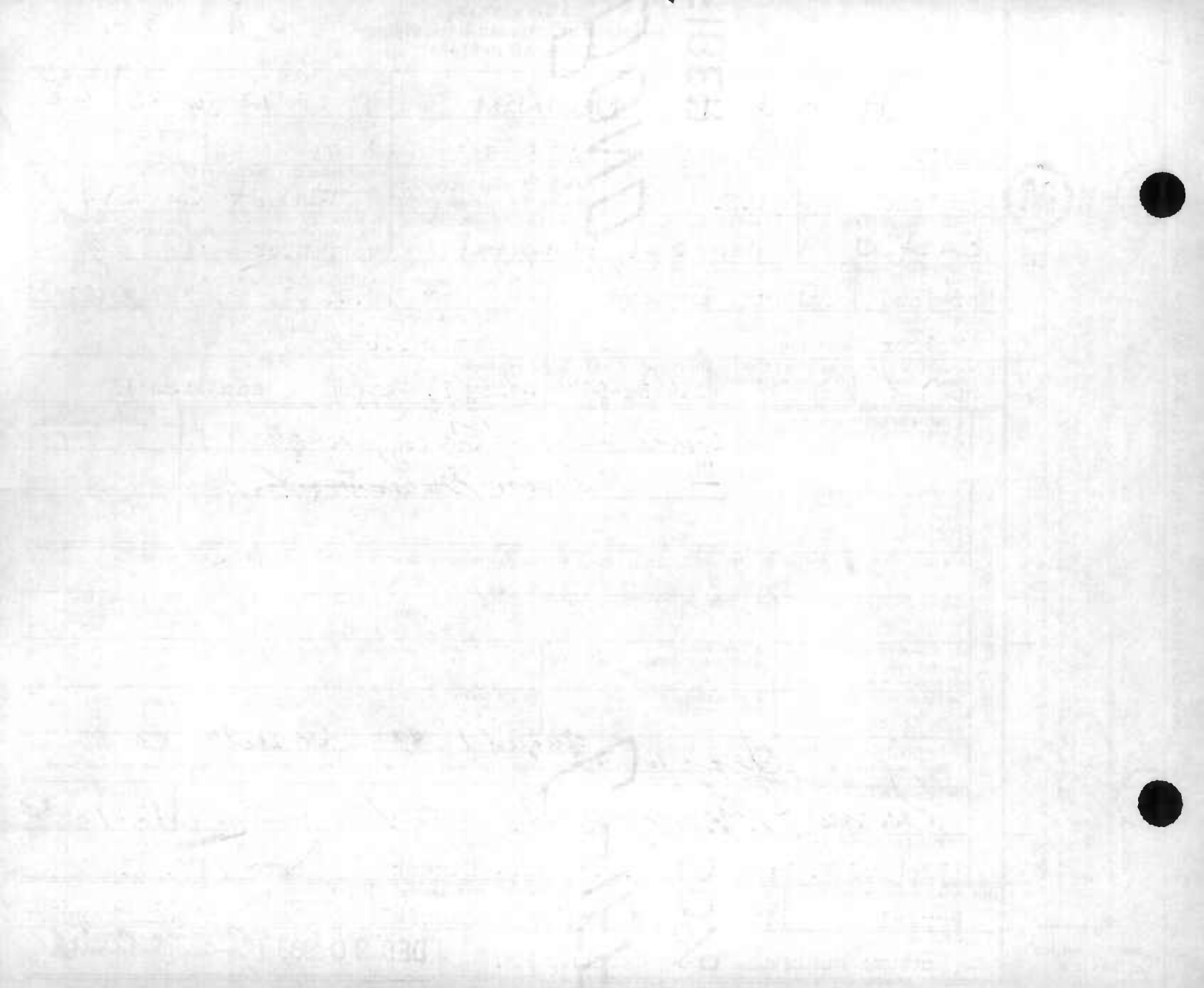
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Howard R Newnam				7a. DATE OF DEATH MONTH DAY YEAR 12 16 83		7b. HOUR 6 P.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.		
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN Cordova	13e. STREET ADDRESS / ZIP CODE R.D. #1, Box 289AB (21625)			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Newnam			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Niblet			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-30-9329		17. INFORMANT ADDRESS Daisy L. Newnam see item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Brain Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from August 1, 1983 to Jan Dec 16, 1983 , that (I) (we) lost saw the deceased alive on Dec 16, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.						
22b. SIGNATURE Richard F. Manegold M.D.				22c. DATE SIGNED 12.16.83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.
22e. ADDRESS Bay Street Easton, Md. 21601				22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-19-1983		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Md.				25. DATE REC'D. BY REGISTRAR DEC 20 1983		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN C. RETH					2a. DATE OF DEATH MONTH DAY YEAR 12/19/83			2b. HOUR 1025P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centerville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 221 Broadway 21617	
14. FATHER'S NAME FIRST MIDDLE LAST William Birckhead				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Wheatley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-09-8818		17. INFORMANT ADDRESS Carolyn Ickes 219 Broadway Centerville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1 DEC , 19 83 , to 10 DEC , 19 83 , that (I) (we) last saw the deceased alive on 9 DEC , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-10-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 13, 1983		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Balt, Md. 21214		25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 4 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

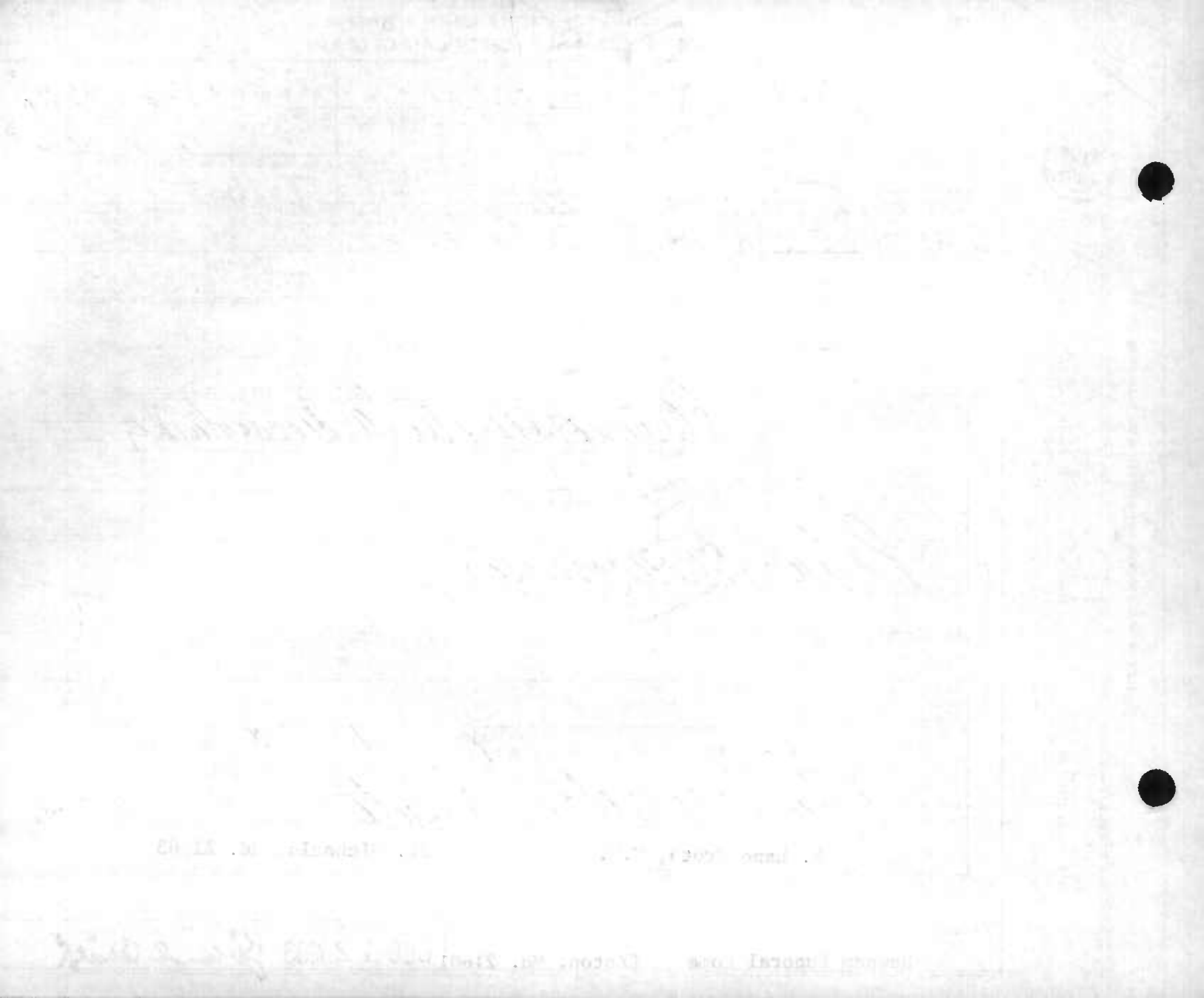
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 2 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lewis Clark			FIRST Rice			LAST			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 6 1983			2b. HOUR 11:00											
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 27 '18		6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.		7. IF UNDER 1 YR. MONTHS DAYS 12 6		8. IF UNDER 24 HRS. HOURS MIN. 12 59		9. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 6 1983		10. BALTIMORE CITY OR COUNTY OF DEATH Talbot									
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker				15. KIND OF BUSINESS OR INDUSTRY Bakery							
16. CITY OR TOWN OF DEATH Easton				17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) mem Hosp Easton				18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a. STATE Maryland				18b. CITY OR TOWN Talbot				18c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				18d. STREET ADDRESS 220 South St. 21654			
19. FATHER'S NAME FIRST MIDDLE LAST Duane Rice				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Case				21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				22. SOCIAL SECURITY NO. 213-12-8249				23. INFORMANT Marjorie O. Rice (see item 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Enteropneustic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) Baker's Pneumonia																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Baker's Pneumonia																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE R. Lane Wroth				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER St. Michaels, Md. 21663				DATE SIGNED 12-7-83											
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, Md. 21663																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12-7-83				23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.											
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Md. 21601								25a. DATE REC'D. BY REGISTRAR DEC 12 1983				25b. REGISTRAR'S SIGNATURE John J. Conner											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
John H. Roberts		December 27, 1983		8:40 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Blk	MONTH DAY YEAR	50	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Ind	USA		Talbot MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Easton	Meedian - The Pines		La Borry		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
MD		Talbot	Easton	224 Glenwood Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Edward H Roberts		Elizabeth Blackwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Rosette - Andrews	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4029 Congestive Heart Failure					2m
DUE TO, OR AS A CONSEQUENCE OF (b) HCVS					10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Bilateral CVA's Amputations					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980, 12/24/83, to 12/27, 1983, that (I) (we) lost saw the deceased alive on 12/24/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
W Whitwood		MD		12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
W Whitwood		Easton Md			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		12/31/83		Copperville Cm	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Easton TA MD		JAN 5 1984		J. E. C.	
24. FUNERAL DIRECTOR NAME		ADDRESS			
George Dashed		Easton Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) James L ROE			2a. DATE OF DEATH MONTH DAY YEAR 12 19 83		2b. HOUR 9 40 A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ice Man		12b. KIND OF BUSINESS OR INDUSTRY Canning	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 5 Judas Street, 21601		14. FATHER'S NAME FIRST MIDDLE LAST James W. Roe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-52-1071		17. INFORMANT James W. Roe (see item 13e)		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MIDBRAIN STROKE 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGENITAL MALFORMATION OF BASE OF SKULL DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS 36 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) did not attended the deceased from 12-19 , 19 83 , to 12-19 , 19 83 , that (I) (we) lost saw the deceased alive on 12-19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Carney				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-21-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md.	
24. FUNERAL DIRECTOR NAME Norman Funeral Home				ADDRESS Easton, Md. 21601		25a. DATE REC'D. BY REGISTRAR DEC 27 1983	
				25b. REGISTRAR'S SIGNATURE James E. Carney			

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RECEIVED

James L. Boy

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EASTON, MASSACHUSETTS

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RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Barbara V Schroeder			2a. DATE OF DEATH MONTH DAY YEAR 12-13-83		2b. HOUR 12 A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York State		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker & Sec.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Still Pond		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harold O Vosburgh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Manning		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 219 34 3422		17. INFORMANT ADDRESS Jack Schroeder Still Pond, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) OVARIAN CARCINOMA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 mo
DUE TO, OR AS A CONSEQUENCE OF (b) _____						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-14 , 19 82 , to 12-13 , 19 83 , that (I) (we) last saw the deceased alive on 12-13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE Stephen B Carney		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-13-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Carney		22e. ADDRESS Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.
24. FUNERAL DIRECTOR NAME Willis Wells		ADDRESS Chestertown, Md.		25. DATE REC'D. BY REGISTRAR DEC 16 1983		

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MAILED 2-21-72

TRUST

ON 12-1-72

1-12-72

1-12-72

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DEBORAH JEAN SCHUYLER			2a. DATE OF DEATH MONTH DAY YEAR December 28, 1983		2b. HOUR 4⁴³ P.M.				
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1955		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 28			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL AT EASTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY food store			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William A. Larrimore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia L. Foreman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220-66-4405		17. INFORMANT ADDRESS William H. Schuyler 111			see item 3	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**
4254
DUE TO, OR AS A CONSEQUENCE OF
(b) **Cardiomyopathy**
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHapprox
8 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/16/83 , 19____, to 12/28/83 , 19____, that (I) (we) lost saw the deceased alive on 12/27/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cynthia M. Lipsitz MD				DEGREE MD		22c. DATE SIGNED 12/28/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CYNTHIA M. LIPSITZ MD				22e. ADDRESS PO BOX 27 Denton, Md. 21629			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-1983		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Maryland	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md. 21601		25a. DATE REC'D. BY REGISTRAR JAN 3 1984	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FREDERICK Lee Sculley			2a. DATE OF DEATH MONTH 12 DAY 22 YEAR 83		2b. HOUR 9:00 M		
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH 5 DAY 10 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard		12b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Henderson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Fred MIDDLE Sculley		15. MOTHER'S MAIDEN NAME FIRST Elsie MIDDLE Moore		13e. STREET ADDRESS Rt 1 Box 82A 21640			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-18-8550		17. INFORMANT Dorothy C. Sculley Henderson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mins Sys							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/15 83 to 12/22 83 , that (I) (we) last saw the deceased alive on 12/15 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wm H Wood		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WOOD		22e. ADDRESS EASTON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-83		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION CITY OR TOWN Greensboro COUNTY Caroline STATE Md.	
24. FUNERAL DIRECTOR John E Boulan's		ADDRESS Greensboro, Md.		DEC 28 1983 BY REGISTRAR John J. Carver			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIOLA G. SHULTS			2a. DATE OF DEATH MONTH DAY YEAR DEC. 24, 1983			2b. HOUR 1 A.M.		
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.		
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Center - The Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John George Gohlinghorst		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Baker		13e. STREET ADDRESS Dover & Harrison Sts. (21601				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-4533		17. INFORMANT ADDRESS Elizabeth G. Cummings Easton, Md.				

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> 4370 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ <i>Chronic Obstructive Lung Disease, Senile Dementia</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> , 19 <i>83</i> , to <i>12/24</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/13</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Wm H Wood</i>		22c. DATE SIGNED 12/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H Wood</i>		22e. ADDRESS EASTON Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-1983		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balt., Maryland	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	
25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CHARLES FRANKLIN SPENCER			2a. DATE OF DEATH MONTH DAY YEAR 12 24 83		2b. HOUR 10 ³⁰ M	
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR MAY 11, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.		
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL AT EASTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCERY STORE		12b. KIND OF BUSINESS OR INDUSTRY OWNER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN MARYLAND TALBOT		13b. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 108 N. HARBOR RD. 21663		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH D. SPENCER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA M. MULLIKIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YEAR STATE WORK DATES) WW II 217-14-8904		17. INFORMANT ADDRESS HELEN M. SPENCER ST. MICHAELS, Md. 21663		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 78 , to 12/24 , 19 83 , that (I) (we) last saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <i>Donald T. Lewers</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD T. LEWERS				22e. ADDRESS Dutchman's Lane, Easton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 28, 1983		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G. MARYLAND
24. FUNERAL DIRECTOR NAME <i>Harmon E. Leonard</i>				25a. DATE REC'D. BY REGISTRAR DEC 30 1983		
				25b. REGISTRAR'S SIGNATURE <i>John J. Lewis</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Health Department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA MAUD Stanford				2a. DATE OF DEATH MONTH DAY YEAR 12-16-1983				2b. HOUR MIN 8 p.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 8 05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 2 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE MD				13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlbrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE S. Main Street 21643	
14. FATHER'S NAME FIRST MIDDLE LAST John Willey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Information Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-22-5354		17. INFORMANT ADDRESS Norman Lee Dean 805 Light Street Salisbury, MD					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2506 IMMEDIATE CAUSE (a) <u>Chronic heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dilated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Periphereal Vascular disease & gangrene 5th left toe</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 12/16/83 that (I) (we) last saw the deceased alive on 12/16/83 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, or from (a) (b) (c) and that the body was not seen after death.											
22b. SIGNATURE PGREGG RHODES MD				22c. DATE SIGNED 12/19/83				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PGREGG RHODES MD				22f. ADDRESS 400 DUTCAMANS LANE, EASTON, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-20-83		23c. NAME OF CEMETERY OR CREMATORY East New Market Cem		23d. LOCATION CITY OR TOWN COUNTY STATE E. New Market, Dorch., MD			
24. FUNERAL DIRECTOR NAME Zeller Funeral Home				24b. ADDRESS East New Market, Md.				25a. DATE REC'D BY REGISTRAR JAN 12 1984			
25b. REGISTRAR'S SIGNATURE [Signature]											

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Indict

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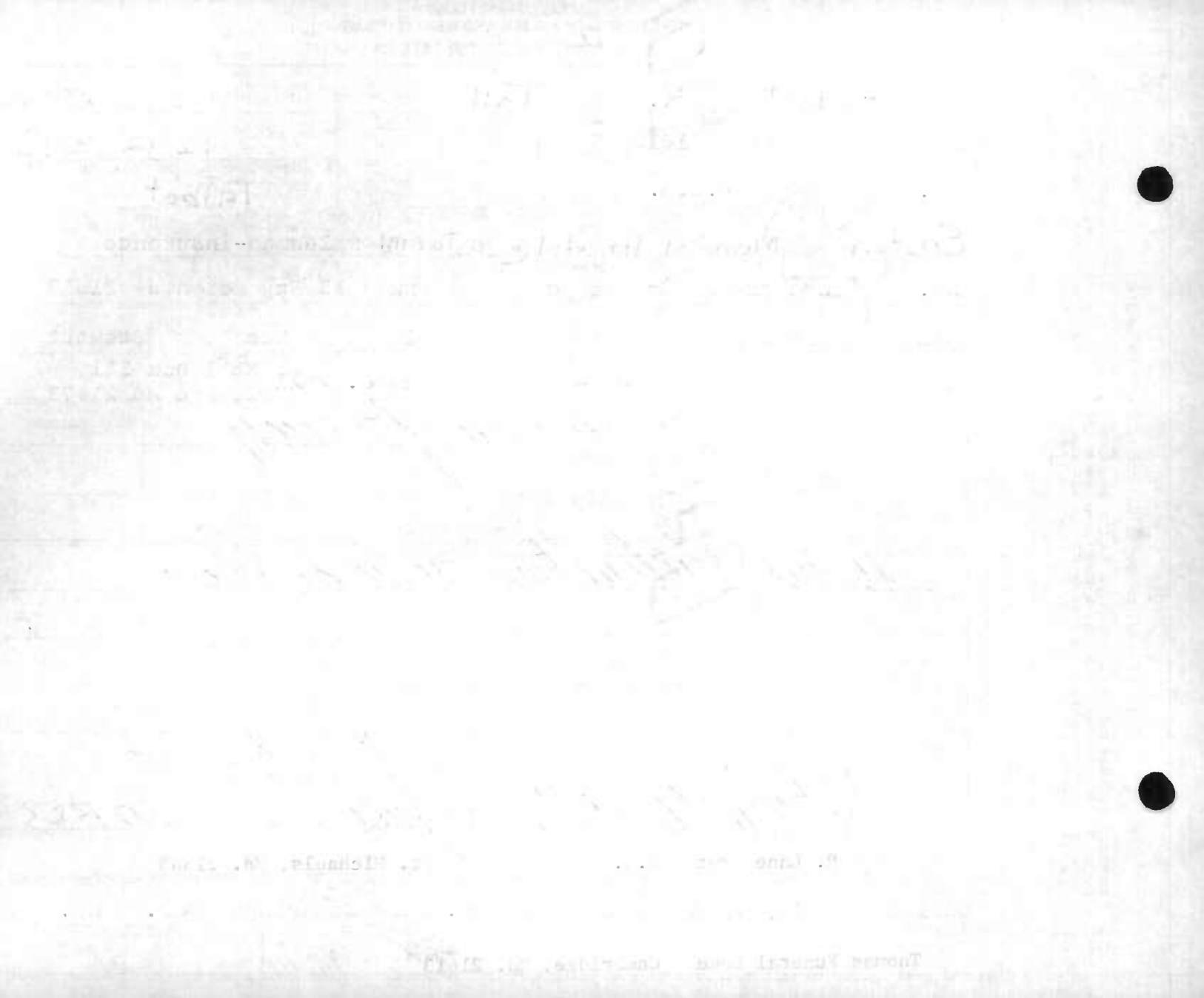
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. BEGIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 34275	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert R. Tall										2b. DATE KNOWN OF DEATH ESTIMATED 12-12-83 12:00 PM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 08 02 1916		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12-12-83 1:00 PM		2d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Tallbot MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital @ Easton Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman-insurance		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13 Bay Heights 21613			
14. FATHER'S NAME FIRST MIDDLE LAST Russell Zebedee Tall					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Lee Stewart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-07-9911		17. INFORMANT Stanley O. Tall ADDRESS Rt 1 Box 311 Trappe Md 21673					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Chronic Obstructive Pulmonary Disease</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>R. Lane Wroth</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>				MEDICAL EXAMINER		DATE SIGNED 12-13-83	
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, Md. 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/15/83		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Thomas Funeral Home Cambridge, Md. 21613											
DATE REC'D. BY REGISTRAR 12-19-83 REGISTRAR'S SIGNATURE <i>John J. Carver</i>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances RICE Terry						2a. DATE OF DEATH MONTH DAY YEAR December 21, 1983		2b. HOUR 8:45 P.M.			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR JUNE 21, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOLTEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN NEAVITT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 206 21652			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. RICE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIANNA BADGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----				16b. SOCIAL SECURITY NO. ----		17. INFORMANT ADDRESS CHARLOTTE T. CONNOLLY P.O. BOX 206 NEAVITT, Md. 21652					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) 4 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2 Sep , 19 80 , to 12-21 , 19 83 , that (I) (we) lost saw the deceased alive on 12-13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carney				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-23-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. CARNEY M.D.				22e. ADDRESS DUTCHMANS LANE EASTON, MARYLAND 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 29		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK MARYLAND					
24. FUNERAL DIRECTOR NAME James E. Ronald St. Michaels				25. DATE REC'D. BY REGISTRAR DEC 30 1983							

BP

10-10-58

December 10, 1958

Dear Sir:

Thank you

for your letter

of November 21, 1958.

I am

very sorry

that

the

U.S.A.

Department

of Education

has

not yet

received

your letter of November 10, 1958.

I am

very

sorry

that the

U.S.A.

Department

of Education

has

not

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received your letter

of November 10, 1958.

I am very sorry

that the U.S.A.

Department of Education

has not yet received

your letter of November

10, 1958.

I am very sorry

that the U.S.A.

Department of Education

has not yet received

your letter of November 10, 1958.

I am very sorry

that the U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 4 2 7 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Ella</u> MIDDLE <u>Moore</u> LAST <u>THOMAS</u> <u>ELLA M. THOMAS</u>			2a. DATE OF DEATH MONTH <u>12</u> DAY <u>30</u> YEAR <u>83</u>		2b. HOUR <u>10²⁰ A.M.</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>January</u> DAY <u>7</u> YEAR <u>1883</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>100</u> YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>TALBOT</u> MD.		
10. CITY OR TOWN OF DEATH <u>EASTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MEMORIAL HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Wife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>			13b. COUNTY <u>Caroline</u>		13c. CITY OR TOWN <u>Ridgely</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>Maryland Ave., P.O. Box 384, 21660</u>								
14. FATHER'S NAME FIRST <u>Samuel</u> MIDDLE <u>Henry</u> LAST <u>Moore</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Elizabeth</u> LAST <u>Bambury</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-05-6296</u>		17. INFORMANT <u>Daughter</u> ADDRESS <u>P.O. Box 384</u> <u>Miss Madge A. Thomas, Ridgely, Md. 21666</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4360</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> 19 <u>83</u> to <u>Dec 30</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Dec 25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Richard F. Manegold MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard F. Manegold, M.D.</u>		22e. ADDRESS <u>Easton, Md. 21601</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jan. 2, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Centreville, Q.A.Co., Md.</u>		
24. FUNERAL DIRECTOR NAME <u>James H. Barton, Jr., Centreville, Md.</u> ADDRESS <u>Barton Funeral Home</u> 21617		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 6 1984</u> <u>John J. Gault</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-54

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LARY W. Toms										20. DATE KNOWN OF DEATH MATED 12 2 19 83										2b. HOUR 2:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-1-1949		6. AGE (IN YEARS) 34 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 12 2 19 83		2d. HOUR 2:45							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot				MD.					
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food store				12b. KIND OF BUSINESS OR INDUSTRY cashier							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bozman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Gen. Del.						21612							
14. FATHER'S NAME J. Stanley Toms										15. MOTHER'S MAIDEN NAME Hildred Sewell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-52-0757		17. INFORMANT ADDRESS Sheryl R. Toms, (see item 13e.)															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cerebral artery, Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Asphyxia																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE R. Lane Wroth				M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 12-2-83									
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M. D.				ADDRESS St. Michaels, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-5-83		23c. NAME OF CEMETERY OR CREMATORY Neavitt Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Neavitt Talbot Md.											
24. FUNERAL DIRECTOR NAME Newnam Funeral Home, Easton, Md. 21601										25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Carver									

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Everett B. Townsend, SR.			2a. DATE OF DEATH MONTH DAY YEAR December 24 1983			2b. HOUR 4:38 AM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Aug. 12, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE AND INDUSTRY WORKING (IFE) locomotive crane engineer railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Delaware				13b. COUNTY Newcastle		13c. CITY OR TOWN wilmington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS A. TOWNSEND				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAOMI TURNER				13e. STREET ADDRESS / ZIP CODE 2 Robert Lane, Monroe Park 99999	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 716-01-6556		17. INFORMANT L. Arnold Townsend		ADDRESS 505 Ruxton Drive Wilmington, Del.	
---	--	--	--	--	--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. 1551 IMMEDIATE CAUSE (a) Cholangiocarcinoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 12/2/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholangiocarcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/28 19 83 , to 12/24 19 83 , that (I) (we) last saw the deceased alive on 12/23 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Thomas Divilio, M.D.				22e. ADDRESS Box 822 Easton, Md. 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-1983		23c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Newcastle, De	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Md.				25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

James M. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Louis A. M. Wade</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 25 83</i>			2b. HOUR <i>4:24 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec 20, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.				
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm Mach.</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Cordova</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>RD 1, Box 212 21625</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Wade</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Louise Lowenson</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>216-01-3711</i>		17. INFORMANT ADDRESS <i>Margaret E. Wade, (see item 13 e)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fatal Anesthesia</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>13 yrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1970</i> , 19 <i>83</i> , to <i>25 Dec</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Nov 83</i> , 19 <i>83</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12-26-83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney, M. D.</i>			22e. ADDRESS <i>Dutchman's Lane, Easton, Md. 21601</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-28-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Pauls Lutheran</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cordova Talbot Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Newnam Funeral Home, Easton, Md. 21601</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		MONTH DAY MIN.	
FIRST MIDDLE LAST			12 21 83		6 28 P M	
3. SEX			4. RACE		5. DATE OF BIRTH	
m			w		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland			USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
EASTON			Memorial Hospital		Farmer-Retired Chickens	
13a. STATE			13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland			Dorchester		FED Fed., Md. 21632	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST			FIRST MIDDLE LAST			
Daniel Williams			Dolly Toulson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No			217-30-7994		Jay Williams Rt #3 Box 248AAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:						
5579 IMMEDIATE CAUSE (a) Multiple System Failure						
DUE TO, OR AS A CONSEQUENCE OF						
(b) mesenteric ischemia						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
		P.M. 19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 20</u> , 19 <u>83</u> , to <u>DEC 21</u> , 19 <u>83</u> , that (we) lost saw the deceased alive on <u>DEC 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.						
22b. SIGNATURE				DEGREE		22c. DATE SIGNED
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/21/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
L. THOMAS DIVILIO				P.O. BOX 822 EASTON, MD 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		12-21-83		Bloomery Cemetery		CITY OR TOWN COUNTY STATE
						Federals. Caroline Md..
24. FUNERAL DIRECTOR						
NAME ADDRESS						
L. Thomas Divilio - Federalsburg, Md.						
25. DATE RECEIVED BY REGISTRAR (TYPE OR PRINT)						
JAN 03 1984						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 4 2 8 2			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene D. Willis				2a. DATE OF DEATH MONTH DAY YEAR 12 12 83				2b. HOUR 9:12 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surgeon		12b. KIND OF BUSINESS OR INDUSTRY Tree			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD 3, Box 487 21601			
14. FATHER'S NAME FIRST MIDDLE LAST John Van Willis Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Bryan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Irene E. Willis (see item 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 ACUTE MYO CARDIAC INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAY 9 YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sep 74, 1974, to Dec 83, 1984, that (I) (we) saw the deceased alive on Dec 12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carney, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-12-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M. D.				22e. ADDRESS Dutchman's Lane, Easton 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-15-83		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock Dorchester Md.			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home, Easton, Md. 21601						25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Carney			

19-12-23

Wills

TABLE

EASTON

19-12-23

Wills

19-12-23

Wills

Wills

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Nelson N. Zimmerman			2a. DATE OF DEATH MONTH DAY YEAR 12 11-83			2b. HOUR 1038 PM				
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 7., 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE R.D. #5, Box 364 (21601)			
14. FATHER'S NAME FIRST MIDDLE LAST Frank A. Nelson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Rowley			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 215-38-0742	
17. INFORMANT ADDRESS Marlin U. Zimmerman, Jr.			See item 13							

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 2028

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Staphylococcal Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c) Malignant lymphoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

36h

2 1/2 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence D. Bohan, M.D.				DEGREE MD • ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-11-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Dutchman's Lane Easton, Md. 21601			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 12-14-1983		23c. NAME OF CEMETERY OR CREMATORY Gravel Hill		23d. LOCATION (CITY OR TOWN COUNTY STATE) Palmyra, Lebanon, Penna.	
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24. FUNERAL DIRECTOR Newham Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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